

COMMISSION ON LEGAL COUNSEL FOR INDIGENTS

Request for Reimbursement for Attorney Fees and Expenses

Billing Date (Month & Year) _____

Name of Attorney	Vendor I.D. No.	Date Appointed	Appointed By	
Mailing Address		City	State	Zip Code
Case Name (Defendant)		Offense	IN <input type="checkbox"/> District Court <input type="checkbox"/> Juvenile Court As <input type="checkbox"/> Indigent Defense Counsel	
District or Juvenile Case No.	County	Judicial District		

REIMBURSEMENT REQUEST

DATE	ITEMIZED SERVICES (ATTACH ADDITIONAL SHEETS IF NECESSARY)	TIME	AMOUNT
ITEMIZED COSTS:			
TOTAL AMOUNT OF FEES AND COSTS FOR WHICH REIMBURSEMENT IS REQUESTED:			

CERTIFICATION

I certify this statement is true and that no compensation for the fees and costs set forth has been received.

Attorney

Date

Please mail to: Commission on Legal Counsel for Indigents
PO Box 149
Valley City, ND 58072